DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 03/20/2000 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 *\$PATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (XZ) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER COMPLETED A BUILDING B. WING 09G193 03/18/2009 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS. CITY, STATE, ZIP CODE 74 W' ST. NW **WESTVEW 02** WASHINGTON, DC 20015 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX PROVIDER'S PLAN OF CORRECTION ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (XS) COMPLETION DATE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION! TAG **DEFICIENCY** {W 000} **INITIAL COMMENTS** (W 000) This monitoring visit was conducted on March 18, 2009. A random sample of three clients was APR - 2 2000 selected from a resident population of three men GOVERNMENT OF THE DISTRICT OF COLUMBIA and three women with various disabilities. The **(**. DEPARTMENT OF HEALTH findings of the survey were based on 645 HEALTH REGULATION ADMINISTRATION observations, interviews with clients and staff in . 825 NORTH CAPITOL ST., N.E., 2ND FLOOR the home and at one day program, as well as a WASHINGTON, D.C. 20002 review of client and administrative records. including incident reports. **(W 159)** 483.430(a) QUALIFIED MENTAL (W 159) 3/27/09 RETARDATION PROFESSIONAL On March 27, 2009, the staff were retrained on documenting Each client's active treatment program must be evacuation drills using eachintegrated, coordinated and monitored by a means of egress, and the quarterly qualified mental retardation professional. schedule for conducting evacuation drills. (see Attachment #1) In the future, the Residential Manager will This STANDARD is not met as evidenced by: ensure that the documentation for Based on interview and record review, the Qualified Mental Retardation Professional evacuation drills is completed (QMRP) failed to ensure the coordination of properly and various means are used services for six of six clients in the facility. (Client by each shift, as well as evacuation #1, Client #2, Client #3, Client #4, Client #5 and drills conducted on each shift on a Client #6) quarterly basis. The finding includes: Cross Refer to W441. The QMRP failed to ensure 11 that staff had received effective training on 3/27/09 documenting evacuation drills under varied The current form used did not list conditions. all five means of egress, therefore, **(W 189)** 483.430(e)(1) STAFF TRAINING PROGRAM (W 189) a new form was developed, (see Attachment #2) Monitoring will be The facility must provide each employee with conducted by the Quality Assurance initial and continuing training that enables the Coordinator. employee to perform his or her duties effectively. efficiently, and competently. LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (XX) DATE red P.West MD 30 try deficiency statement ending with an exterior (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that their safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days

bildwing the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 lays following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued rogram participation.

PRINTED: 03/20/2009 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X3) DATE SURVEY O(1) PROVIDER/SUPPLIER/CLIA (C2) MEETIPLE CONSTRUCTION AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A BUILDING A. .. B. WING 09G193 400 03/18/2009 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE

74 W ST. NW WESTVIEW 02 **WASHINGTON, DC 20015** SUMMARY STATEMENT OF DEFICIENCIES (X4) IO PROVIDER'S PLAN OF CORRECTION (XS) COMPLETION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FUL PREFIX TAG REGULATORY OR LSC (DENTIFYING INFORMATION) TAG DEFICIENCY) (W 189) Continued From page 1 (W 189) 3/27/09 On March 27, 2009, the staff were retrained on documenting This STANDARD is not met as evidenced by: Based on observation, staff interview and record evacuation drills using each: review, the facility failed to ensure that each means of egress, and the quarterly employee had been provided with adequate schedule for conducting evacuation training that enabled the employee to perform his drills. (see Attachment #1) In the or her duties effectively, efficiently and 40.0 future, the Residential Manager will 100 competently for six out of six clients in the facility. ensure that the documentation for (Client #1, Client #2, Client #3, Client #4, Client evacuation drills #5 and Client #6) is completed NAL 1 properly and various means are used by each shift, as well as evacuation 1. drills conducted on each shift on a The finding includes: quarterly basis. Cross Refer to W441. The facility failed to ensure that staff had received effective training on documenting evacuation drills under varied conditions. 3/27/09 **(W 441)** On March 27, 2009, the staff were 483.470(i)(1) EVACUATION DRILLS (W 441). retrained on documenting The facility must hold evacuation drills under evacuation drills. using varied conditions. means of egress, and the quarterly schedule for conducting evacuation drills. (see Attachment #1) In the This STANDARD is not met as evidenced by: future, the Residential Manager will Based on staff interview and record verification. 1711 ensure that the documentation for the facility failed to hold evacuation drills under varied conditions for six of six clients in the evacuation drills is completed 43 properly and various means are used facility. (Client #1, Client #2, Client #3, Client #4. . Client #5 and Client #6) by each shift, as well as evacuation drills conducted on each shift on a The finding includes: quarterly basis. Review of the fire drill log book on March 18. 2009, at approximately 11:45 AM revealed two basement exits and the exit leading from Client #1's bedroom had not been used during stimulated fire drills. In an interview with the Qualified Mental Retardation Professional

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(x2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED R 03/18/2009		
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 2 (QMRP)on March 18, 2009 at approximately 11:50 AM it was acknowledged the two basement exits and the exit leading from Client #1's bedroom had not been used during stimulated fire drills. There was no evidence on file at the time of survey to substantiate that all exits were used during the evacuation drills.			×	PROVIDER'S PLAN OF CORRECT	PROVIDER'S PLAN OF CORRECTION ACH CORRECTIVE ACTION SHOULD BE SS-REFERENCED TO THE APPROPRIATE DATE		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED B. WING HFD03-0202 03/18/2009 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 74 W ST, NW **WESTVIEW 02 WASHINGTON, DC 20015** (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (XS) COMPLETE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD SE CROSS-REFERENCED TO THE APPROPRIATE PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE DEFICIENCY ;;; (R 000) **INITIAL COMMENTS** (R 000) 1.0 This monitoring visit was conducted on March 18. 2009. A random sample of three residents was selected from a resident population of three men and three women with various disabilities. The findings of the survey were based on observations, interviews with residents and staff in the home and at one day program, as well as a review of resident and administrative records, including incident reports. (R 125) 4701.5 BACKGROUND CHECK REQUIREMENT (R 125) 3/09/09 A criminal background check had The criminal background check shall disclose the criminal history of the prospective employee or been conducted for Staff #2 on contract worker for the previous seven (7) years, 03/09/09, but was inadvertently in all jurisdictions within which the prospective not given to the surveyor at the employee or contract worker has worked or time of the monitoring visit. resided within the seven (7) years prior to the check. (See Attachment #3). A criminal background check 4/04/09 This Statute is not met as evidenced by: will be requested and obtained Based on interview and review of records, the for Staff #6 by April 6. GHMRP failed to ensure criminal background checks disclosed the criminal history of any prospective employee or contract worker for the previous seven (7) years, in all jurisdictions within which the prospective employee or contract worker has worked or resided within the seven (7) years prior to the check for two of six staff in the facility. (Staff #2 and Staff #6). The finding includes: Review of the personnel records on March 18, 2009 at approximately 1:00 PM revealed that the GHMRP failed to provide evidence that ensured criminal background checks were on file for two direct care staff. In an interview with the Qualified Mental Retardation Professional (QMRP) on rd R West PPLIER REPRESENTATIVE'S SIGNATURE ABORATORY DIRECTOR'S OR PROVIDER/SLI

Health Regulation Administration

STATE FORM

PRINTED: 03/20/2009 FORM APPROVED

Health Regulation Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING B. WING HFD03-0202 03/18/2009 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **WESTVIEW 02 WASHINGTON, DC 20015** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (XS) COMPLETE DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG **DEFICIENCY**) {R 125} Continued From page 1 (R 125) March 18, 2009 at approximately 1:15 PM it was acknowledged Staff #2 and Staff #6 did not have criminal background checks for the previous seven (7) years, in all jurisdictions where they have worked or resided. There was no documented evidence all staff had criminal g GASS background checks for the previous seven (7) years, in all jurisdictions where they have worked or resided.

Health Regulation Administration STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION DENTIFICATION NUMBER COMPLETED A. BUILDING B. WING HFD03-0202 03/18/2009 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 74 W ST. NW **WESTVIEW 02** WASHINGTON, DC 20015 **SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION** (X4) ID (XII) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (1 000) **INITIAL COMMENTS** {1 000} 13 This monitoring visit was conducted on March 18. 2009. A random sample of three residents was selected from a resident population of three men and three women with various disabilities. The 140 findings of the survey were based on 5 " observations, interviews with residents and staff in the home and at one day program, as well as a review of resident and administrative records. including incident reports. v. (1 090) 3504.1 HOUSEKEEPING {I 090} The interior and exterior of each GHMRP shall be maintained in a safe, clean, orderly, attractive, and sanitary manner and be free of accumulations of dirt, rubbish, and objectionable odors. This Statute is not met as evidenced by: Based on observation and interview, the GHMRP failed to ensure the interior of the GHMRP was maintained in a safe manner. 3/22/09 The handle for the back storm door The finding includes: was replaced and the door can now Observation on March 18, 2009, at approximately close securely. In the future, the 12:30 PM, revealed the back storm door was Residential Manager will conduct missing a door handle and the door could not be weekly house rounds to check for closed securely. In an interview with the Qualified any maintenance concerns and will Mental Retardation Professional (QMRP) on March 18, 2009, at approximately 12:35 PM it in turn report them to the was acknowledged the back storm door was Environmental Manager for repair, missing a door handle and the door could not be this process will be monitored by closed securely. There was no evidence the back the Quality Assurance Coordinator. storm door was maintained in a safe manner. (1 206) 3509.6 PERSONNEL POLICIES {1 206}

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/BUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0202		(X2) MULTIPLE CONSTRUCTION A BUILDING B. WING		(X3) DATE SURVEY COMPLETED R 03/18/2009			
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(1 206)	Each employee, pri annually thereafter, certification that a h performed and that	ige 1 ior to employment an , shall provide a phys nealth inventory has i the employee 's he her to perform the re	icien ' s been alth status	{1 206}	Each staff person listed Statement of Deficiencies was given a letter to indichis/her health certificate (see Attachment #4). certificate is not received to 18, 2009, he she will be refrom the schedule. In the the Residential Manage	Report ate that is due. If the by April emoved future,	3 <i> 27 0</i> 9		
	This Statute is not met as evidenced by: Based on staff interview and record review, the GHMRP failed to ensure its staff received annual health screenings for seven of fourteen direct care staff. (Staff #1, Staff #2, Staff #3, Staff #4, Staff #5, Staff #6 and Staff #7) The finding includes:				ensure that all health center for the staff are update maintained in his/her perfected for review by moragencies. This process monitored by the Assurance Coordinator.	ed and ersonnel nitoring	and onnel toring ill be		
	at approximately 12 failed to provide evi- examinations for se interview with the CI Professional (QMRI approximately 12:50 Staff #1, Staff #2, S Staff #8 and Staff # screenings on file.	el records on Merch 1:45 PM, revealed the idence of physical iven direct care staff. Ivelified Mental Reta P)on March 18, 2006 0 PM it was acknowle italf #3, Staff #4, Staff 7 did not have annual There was no docum ad annual health scre	E GHMRP In an rdation I, at edged if #5, at health ented						
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